EXHIBIT E

01/22/2013 05:21 5186890035 REED FERENCE PAGE 02/05

12:56:21 PM 20231642619A4

ADA Dental Claim Form

ADA VERSION 2012

HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)
   - ☐ Statement of Actual Services
   - ☒ Request for Predetermination/Preauthorization
   - ☐ EPSDT / Title XIX
2. Predetermination/Preauthorization Number

INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code

DentaQuest
PO Box 2906
Milwaukee, WI 53201-2906

OTHER COVERAGE (Mark applicable box and complete items 5–11. If none, leave blank.)

4. Dental? ☐ Medical? ☐ (If both, complete 5–11 for dental only.)
5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)
6. Date of Birth (MM/DD/CCYY)
7. Gender ☐ M ☐ F
8. Policyholder/Subscriber ID (SSN or ID#)
9. Plan/Group Number
10. Patient's Relationship to Person named in #5 ☐ Self ☐ Spouse ☐ Dependent ☐ Other
11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

McKenna, Jessica
[redacted]
Middle Grove, NY 12850

13. Date of Birth (MM/DD/CCYY) [redacted]
14. Gender ☐ M ☒ F
15. Policyholder/Subscriber ID (SSN or ID#) 10000396
16. Plan/Group Number
17. Employer Name

PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above ☒ Self ☐ Spouse ☐ Dependent Child ☐ Other
19. Reserved For Future Use
20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code
21. Date of Birth (MM/DD/CCYY)
22. Gender ☐ M ☐ F
23. Patient ID/Account # (Assigned by Dentist) 109415 40648

RECORD OF SERVICES PROVIDED

	24. Procedure Date (MM/DD/CCYY)	25. Area of Oral Cavity	26. Tooth System	27. Tooth Number(s) or Letter(s)	28. Tooth Surface	29. Procedure Code	29a. Diag. Pointer	29b. Qty.	30. Description	31. Fee
1		10				D7951		01	Sinus Graft/RidgeAugmen.-late	3200.00
2		20				D7951		01	Sinus Graft/RidgeAugmen.-late	3200.00
3		10				D7950		01	Guided bone regeneration	3000.00
4		20				D7950		01	Guided bone regeneration	3000.00
5										
6										
7										
8										
9										
10										

32. Missing Teeth Information (Place an "X" on each missing tooth.)
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

33. Diagnosis Code List Qualifier ☐ (ICD-9 = B; ICD-10 = AB)
34a. Diagnosis Code(s) (Primary diagnosis in "A") A C B D

31a. Other Fee(s)
32. Total Fee 12400.00

35. Remarks

AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by any dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X Patient Signature on file 06/12/2023
Patient/Guardian Signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X
Subscriber Signature Date

BILLING DENTIST OR DENTAL ENTITY (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber.)

38. Name, Address, City, State, Zip Code

Sean Ference DDS
838 Western Avenue
Albany, NY 12203

39. NPI 1609360999
40. License Number 061790
41. SSN or TIN 872775809
42. Phone Number (518) 489-3201
42a. Additional Provider ID

ANCILLARY CLAIM/TREATMENT INFORMATION

43. Place of Treatment 11 (e.g. 11=office; 22=OP Hospital) (Use "Place of Service Codes for Professional Claims")
44. Enclosures (Y or N) ☐
45. Is Treatment for Orthodontics? ☒ No (Skip 45-47) ☐ Yes (Complete 45-47)
46. Date Appliance Placed (MM/DD/CCYY)
47. Months of Treatment Remaining
48. Replacement of Prosthesis ☐ No ☐ Yes (Complete 49)
49. Date of Prior Placement (MM/DD/CCYY)
50. Treatment Resulting from ☐ Occupational Illness/Injury ☐ Auto accident ☐ Other accident
51. Date of Accident (MM/DD/CCYY)
52. Auto Accident State

TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X Sean Ference 06/12/2023
Signed (Treating Dentist) Date

54. NPI 1609360999
55. License Number 061790
55a. Provider Specialty Code 1223P0300X
56. Address, City, State, Zip Code
838 Western Avenue
Albany, NY 12203
57. Phone Number (518) 489-3201
58. Additional Provider ID

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[redacted]
Middle Grove, NY 12850
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32. Total Fee 12400.00

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X Patient Signature on file 06/12/2023
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Albany, NY 12203
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42. Months of Treatment Remaining
43. Replacement of Prosthesis [ ] No [ ] Yes (Complete 44)
44. Date of Prior Placement (MM/DD/CCYY)
45. Treatment Resulting from [ ] Occupational Illness/Injury [ ] Auto accident [ ] Other accident
46. Date of Accident (MM/DD/CCYY)
47. Auto Accident State

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55. License Number 061790
56. Address, City, State, Zip Code
838 Western Avenue
Albany, NY 12203
56a. Provider Specialty Code 1223P0300X
57. Phone Number (518) 489-3201
58. Additional Provider ID

CAPITAL REGION
Periodontics & Dental Implants

Reed Ference DDS, M. DENT. SC
Sean Ference DDS, M. DENT. SC
838 Western Ave
Albany, NY 12203
(518) 489-3201
www.albanyperioandimplants.com

Fax

To:	Claims Dept.	From:	Lanye
Fax:	(262) 834-3589	Pages:	5
Phone:		Date:	
Re:		Cc:	

☐ Urgent ☐ For review ☐ Please comment ☐ Please reply ☐ Please recycle

Comments: I've sent this to Nascentia as well.

100 YEARS
Legal Aid Society

40 New Street, Saratoga Springs, New York 12866
(800) 828-0087 | (518) 587 5188 | Fax (518) 587-0959
This office serves Saratoga, Warren and Washington Counties

[illegible], President | [illegible], Executive Director | Peter D. Racette, Deputy Director | [illegible], Deputy Director | [illegible], Deputy Director

May 30, 2023

Via Facsimile only:
Sean Ference D.D.S.
835 Western Ave.
Albany NY 12203
Fax no.: 518-689-0035

In re: *Jessica McKenna,* [redacted]

Dear Dr. Ference:

Our office is assisting your patient, Ms. Jessica McKenna with an appeal of a prior authorization denial by DentaQuest. Ms. McKenna shared with us that on or about April 20, 2023 your office called DentaQuest for a pre-authorization for services, which was verbally denied. We are in the process of submitting an appeal of that verbal denial. Please provide us with a copy of the request for services, or otherwise let us know the procedure codes for the denied services. We would like to include specific codes in the appeal request. Please send us a copy of the documents via fax to (518)587-0959, or call me at (518)587-5188, ext. 446 to provide the codes.

A HIPAA Authorization, signed by Jessica McKenna is enclosed.

Should you have any questions or concerns about this request, please contact me at ph: 518-587-5188, ext. 446. Thank you for your assistance with this matter.

Kindest regards,

Legal Aid Society of Northeastern New York, Inc. by Yoana Konstantinova, Esq.
Senior Attorney
40 New Street
Saratoga Springs NY 12866

Cc: Jessica McKenna

PRIMARY CARE

Complex Care Center

Adela Florescu, DDS, MS
Director of Dental Services at Complex Care Center
905 Culver Rd, Rochester, NY, 14609

UNIVERSITY of ROCHESTER MEDICAL CENTER
MEDICINE of THE HIGHEST ORDER

Re: Jessica, Antonia [redacted]

July 14, 2021

To whom it may concern,
Our mutual patient Jessica McKenna was recently seen for evaluation and treatment at The Complex Care Center, Dental clinic, Eastman Institute for Oral Health, University of Rochester.

This patient's complex medical history includes familial Cold Autoinflammatory disease, severe exocrine pancreatic insufficiency, small fiber neuropathy, autonomic dysfunction, bile duct dilatation, chronic pancreatitis, colitis, colonic ileitis, fatty liver, hypermobility syndrome, hypoglycemia, joint and limb edema, livedo reticularis, lymphadenopathy, lymphedema, malabsorption, mega colon, migraines, non-necrotizing hemosiderotic amyloidosis, pelvic venous compression, poly arthritis, post- postural orthostatic tachycardia syndrome vaso vagal inhibitory reflex, Raynaud's dx, Dry mouth. Allergies to Advair, Gluten, Stimulant laxatives, Zofran, aspirin.

History of problem: Jessica is 24 y old female in our care for dental and medical needs. We provided full mouth extractions at the Operating Room settings with General Anesthesia on 2/2020. We fabricated complete dentures on 7/2020, unfortunately with side effect of possible severe local allergic reaction to acrylic bases of the dentures.

Based on clinical and x-rays dental examination the diagnosis includes:
- Edentulous maxilla and mandible.

The current assessment suggests:
- Patient has been treated at our recommendation at OR Strong recently and all remaining teeth were removed during general anesthesia visit.
- Our treatment plan included replacing the missing teeth with dentures.
- Patient experienced localized allergic reactions to acrylic bases of dentures and did not tolerate to wear the dentures.
- Patient is struggling with food intake as she is not able to use the dentures and it affects her wellbeing.
- Alternative treatment plan would include placement of implants which would support maxillary and mandibular bridges or overdentures, usually this treatment is not covered by insurance.

Jessica's underlying medical disease limits her ability to tolerate and manage a removable denture option. We suggest to restore the function of dentition by treatment alternative of fixed bridges supported by implants due to significant declining health due to malnutrition. We believe that restoration of dentition will benefit patients wellbeing overall.

Thank you for consideration to support this treatment plan.
Best Regards,

Adela Florescu, DDS, MS

905 Culver Rd, Rochester, NY 14609
Appointments: 585-279-7000
www.cce.smile.edu
fax: 585-288-1381